PHYSICIAN ASSISTANT
APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS
FOR THE BIENNIAL REGISTRATION PERIOD 2011 - 2013
NEVADA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board

License No._____

File No._____
(For Board Use Only)

I hereby apply for reinstatement to active status and enclose the appropriate fee as indicated below:

_____PHYSICIAN ASSISTANT REINSTATEMENT FEE: $800.00

You may pay by check, cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two percent (2%) service fee will be assessed for payment by credit card.

NAME: _____

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

PLEASE NOTE:

NAC 630.350 (3) Renewal of license; suspension and reinstatement of license.
(3) If a licensee fails to pay the fee for biennial registration after it becomes due, his or her license to practice in this State is automatically suspended. Within 2 years after the date the license is suspended, the holder may be reinstated to practice as a physician assistant if the holder:
(a) Pays twice the amount of the current fee for biennial registration to the Secretary-Treasurer of the Board; and
(b) Is found to be in good standing and qualified pursuant to this chapter (630 of NAC).

- YOU WILL NOT BE REINSTATED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM.
- YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."
- ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM IS PUBLIC INFORMATION.

PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration requires the submission of proof of completion of forty (40) hours of American Academy of Physician Assistants (AAPA) OR AMA Category 1 continuing medical education (CME), which includes two (2) hours of CME in medical ethics; **completed during the preceding 24-month time period of the date of your submission of this form**. Submit your proof of completion of CME with your completed ***APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION*** form. (See last page of this form for CME statement.)

2. If your name and/or address have changed, clearly indicate the change in the space provided below. Please be advised, the address you indicate below is viewable on the NSBME website and is listed as the public address. Also, please indicate your current public telephone and fax numbers. [Please note: if your name has changed, a copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

E-mail address_____

3. List name(s) of your supervising physician(s) with their addresses and phone numbers for EACH and EVERY practice location:

Supervising Physician Name: Address(es) of Practice Location(s): Phone Number(s):

_____

_____

(If more space is needed, attach a separate sheet.)

4. Indicate below your primary and secondary scopes of practice using the following codes:

SCOPES OF PRACTICE CODES

1	ADDICTION MEDICINE	41	NEOPLASTIC DISEASES	81	PEDIATRIC, RHEUMATOLOGY
2	ADOLESCENT MEDICINE	42	NEPHROLOGY	82	PEDIATRIC, SURGERY
3	AEROSPACE MEDICINE	43	NEUROLOGY	83	PEDIATRIC, UROLOGY
4	ALLERGY	44	NEURO-OPHTHALMOLOGY	84	PEDIATRICS
5	ALLERGY/IMMUNOLOGY	45	NEUROPATHOLOGY	85	PHYSICAL MEDICINE/REHABILITATION
6	AMBULATORY MEDICINE	46	NEURORADIOLOGY	86	PREVENTIVE MEDICINE
7	ANESTHESIOLOGY	47	NON-CONVENTIONAL MEDICINE	87	PSYCHIATRY
8	BLOODBANKING	48	NUCLEAR MEDICINE	88	PSYCHOANALYSIS
9	BRONCO-ESOPHAGOLOGY	49	NUTRITION	89	PUBLIC HEALTH
10	CARDIOVASCULAR DISEASES	50	OBSTETRICS	90	PSYCHOMATIC MEDICINE
11	CATSCAN/ULTRASOUND	51	OBSTETRICS/GYNECOLOGY	91	PULMONARY DISEASES
12	CHILD NEUROLOGY	52	OCCUPATIONAL MEDICINE	92	RADIOLOGY
13	CHILD PSYCHIATRY	53	ONCOLOGY	93	RADIOLOGY, DIAGNOSTIC
14	CLINICAL PHARMACOLOGY	54	ONCOLOGY, GYNECOLOGICAL	94	RADIOLOGY, INTERVENTIONAL
15	CRITICAL CARE	55	ONCOLOGY, HEMATOLOGY	95	RADIOLOGY, NUCLEAR
16	DERMATOLOGY	56	ONCOLOGY, RADIATION	96	RADIOLOGY, THERAPEUTIC
17	DERMATOPATHOLOGY	57	ONCOLOGY, SURGICAL	97	RADIOLOGY, VASCULAR
18	EMERGENCY MEDICINE	58	OPHTHALMOLOGY	98	RHEUMATOLOGY
19	ENDOCRINOLOGY	59	OTOLARYNGOLOGY	99	RHINOLOGY
20	FAMILY PRACTICE	60	OTOLOGY	100	SLEEP DISORDERS
21	GASTROENTEROLOGY	61	PAIN MANAGEMENT	101	SPORTS MEDICINE
22	GENERAL PRACTICE	62	PATHOLOGY	102	SURGERY, ABDOMINAL
23	GERIATRIC PSYCHIATRY	63	PATHOLOGY, ANATOMIC	103	SURGERY, CARDIOTHORACIC
24	GERIATRICS	64	PATHOLOGY, CLINICAL	104	SURGERY, CARDIOVASCULAR
25	GYNECOLOGY	65	PATHOLOGY, FORENSIC	105	SURGERY, COLON/RECTAL
26	HAIR TRANSPLANTATION	66	PEDIATRIC, ALLERGY	106	SURGERY, GENERAL
27	HEMATOLOGY	67	PEDIATRIC, CARDIOLOGY	107	SURGERY, HAND
28	HOMEOPATHY	68	PEDIATRIC, CRITICAL CARE	108	SURGERY, HEAD/NECK
29	HYPNOSIS	69	PEDIATRIC, EMERGENCY MEDICINE	109	SURGERY, MAXILLOFACIAL
30	IMMUNOLOGY	70	PEDIATRIC, ENDOCRINOLOGY	110	SURGERY, NEUROLOGICAL
31	INFECTIOUS DISEASES	71	PEDIATRIC, GASTROENTEROLOGY	111	SURGERY, ORTHOPEDIC
32	INFERTILITY	72	PEDIATRIC, HEMATOLOGY/ONCOLOGY	112	SURGERY, PLASTIC
33	INTERNAL MEDICINE	73	PEDIATRIC, INFECTIOUS DISEASES	113	SURGERY, THORACIC
34	LARYNGOLOGY	74	PEDIATRIC, INTENSIVIST	114	SURGERY, TRANSPLANT
35	LEGAL MEDICINE	75	PEDIATRIC, NEPHROLOGY	115	SURGERY, TRAUMATIC
36	MATERNAL/FETAL MEDICINE	76	PEDIATRIC, NEUROLOGY	116	SURGERY, UROLOGIC
37	MEDICAL ACUPUNCTURE	77	PEDIATRIC, OPHTHALMOLOGY	117	SURGERY, VASCULAR
38	MEDICAL ETHICS	78	PEDIATRIC, PHYSIATRY	118	TOXICOLOGY
39	MEDICAL GENETICS	79	PEDIATRIC, PULMONARY	119	URGENT CARE
40	NEO/PERINATAL MEDICINE	80	PEDIATRIC, RADIOLOGY	120	UROLOGY

Code **Code**

Primary Scope of Practice _____ **Secondary Scope of Practice** _____

All of the following questions refer to the preceding 24-month time period of the date of your submission of this form or since your last renewal.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological condition or disorder.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS* FORM.

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice as a physician assistant with reasonable skill and safety? _____Yes _____No

2. If you currently have a medical condition which in any way impairs or limits your ability to practice as a physician assistant, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____Yes _____No _____N/A

3. If you currently use chemical substances, does your use in any way impair or limit your ability to practice as a physician assistant with reasonable skill and safety? _____Yes _____No _____N/A

4. Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? _____Yes _____No

5. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? _____Yes _____No

6. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. (If "Yes," attach explanation on separate sheet.)

_____Yes _____No

8. Have you been denied a license or certificate to practice as a physician assistant, or in any other healing art, or permission to take an examination to practice as a physician assistant or in any other healing art(s) in any state, country or U.S. territory? _____Yes _____No

9. Have you had a physician assistant license or certificate, or license or certificate to practice in any other healing art, revoked, suspended, limited, or restricted in any state, country or U.S. territory? _____Yes _____No

10. Have you voluntarily surrendered a license or certificate to practice as a physician assistant, or in any other healing art, in any state, country or U.S. territory?

_____Yes _____No

11. Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization?

_____Yes _____No

12. Have you been: a) asked to respond to an investigation, b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician assistant by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners?

_____Yes _____No

13. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?

_____Yes _____No

14. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action.

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.)	To (Mo./Yr.)

(If more space is needed, attach a separate sheet.)

CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

SAFE INJECTION PRACTICE ATTESTATION

Applicants must review guidelines of the Centers for Disease Control and Prevention concerning the transmission of infectious agents through safe injection practices:

http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html - or - http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

Applicant: _____ Date: _____

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

Please place a check mark next to one of the following statements:

_____ (a) I was initially licensed in Nevada prior to or during the time period July 1, 2009 through December 31, 2009 and completed a minimum of forty (40) hours of AAPA or AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2010 through June 30, 2010, the second six months of the past biennial period, and completed a minimum of thirty (30) hours of AAPA or AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2010 through December 31, 2010, the third six months of the past biennial period, and completed a minimum of twenty (20) hours of AAPA or AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics;

_____ (d) I was initially licensed in Nevada during the time period January 1, 2011 through June 30, 2011, the fourth six months of the past biennial period, and completed a minimum of ten (10) hours of AAPA or AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**

- **YOUR COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME) COMPLETION WILL NOT BE RETURNED TO YOU.**

HOME ADDRESS & PHONE NUMBER ***(REQUIRED)***

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

BY SIGNING ON THE SIGNATURE LINE BELOW:

1) I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;

2) I UNDERSTAND THAT THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* OF LICENSE WILL BE REJECTED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND

3) I UNDERSTAND THAT THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* OF LICENSE WILL BE REJECTED AS INCOMPLETE IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME); (b) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (c) WRITTEN EXPLANATION (S) TO ANY "YES" ANSWER(S).

_____ _____

Date **Signature** **(SIGNATURE STAMP UNACCEPTABLE)**

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from the application, please mail to:
Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510-7238
or fax to:
775-688-2321

Please type or print legibly.

Name of Applicant: _____

Method of Payment: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

_____

_____

_____

Phone Number: _____

Credit Card Number: _____

Expiration Date: _____ / _____
(MM) (YYYY)

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of $ _____, and an additional 2% service fee.

Printed Name: _____

Authorized Signature: _____ Date: _____